FY1998

Financial Statement Audit

Health Care Financing Administration (HCFA)

Testimony of

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Inspector General

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Government Management, Information and
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Office of Inspector General
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Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services, and I am pleased to report to you on our audits of Fiscal Year (FY) 1998 Medicare fee-for-service payments and the Health Care Financing Administration (HCFA) financial statements. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

The Office of Inspector General (OIG) recently issued its third annual estimate of the extent of fee-for-service payments that did not comply with laws and regulations. As part of our analysis, we profiled all 3 years' results and identified specific trends, where appropriate, by the major types of errors found over the 3 years and the types of health care providers whose claims were erroneous. As required by the Government Management Reform Act of 1994, we also issued our third comprehensive financial statement audit of HCFA. The purpose of financial statements is to provide a complete picture of agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the statements.

My statement today will focus first on the notable reduction in Medicare payment errors we have found and the problem areas where further effort is needed. Then I will briefly highlight the significant findings of our financial statement audit.

Before I begin, I would like to acknowledge the cooperation and support we received from the Department, HCFA, and the General Accounting Office (GAO). HCFA's assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO) was invaluable in reviewing benefit payments. Also, I want to point out that we worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government. The Department is one of the most significant agencies included in these Governmentwide statements.

MEDICARE PAYMENT ERRORS

Overview

The HCFA is the largest single purchaser of health care in the world. With expenditures of approximately $310 billion, assets of $181 billion, and liabilities of $40 billion, HCFA is also the largest component of the Department. Medicare and Medicaid outlays represent 34.2 cents of every dollar of health care spent in the United States in 1998. In view of Medicare's 39 million beneficiaries, 860 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the Medicare program is inherently at high risk for payment errors.

Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records.

However, Medicare regulations specifically require providers to retain supporting documentation and to make it available upon request.

As part of our first audit of HCFA's financial statements for FY 1996, we began reviewing claim expenditures and supporting medical records. We did this because of the high risk of Medicare payment errors, the huge dollar impact on the financial statements (e.g., $176.1 billion in FY 1998 fee-for-service claims), and our statutory requirement to report on compliance with laws and regulations. This year, for the first time, we issued the results of our claim testing separately from the financial statement audit report.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Sampling Methodology

To accomplish our objective, we used a stratified, multistage sample design. The first stage consisted of a selection of 12 contractor quarters during FY 1998 (10 from the first, second, and third quarters and 2 from the fourth quarter). The selection of the contractor quarters was based on probabilities proportional to the FY 1997 Medicare fee-for-service benefit payments. The second stage consisted of a stratified random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,540 claims valued at $5.6 million for review.

For each selected beneficiary during the 3-month period, we reviewed all claims processed for payment. We first contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response, we made numerous follow-up contacts by letter, telephone calls, and/or onsite visits. Then medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and PROs assessed the medical records to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on previously identified improper billing practices, to determine whether (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Sample Results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during FY 1998, we found that 915 claims did not comply with Medicare laws and regulations. **By projecting these sample results, we estimated that FY 1998 net improper payments totaled about $12.6 billion nationwide, or about 7.1 percent of total Medicare fee-for-service benefit payments.** This is the mid-point of the estimated range, at the 95 percent confidence level, of $7.8 billion to $17.4 billion, or 4.4 percent to 9.9 percent.

Medical review personnel detected 90 percent of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors we found.

As in past years, the improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. We have, however, quantified the estimated provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded, or noncovered. These were the major error categories noted over the last 3 years.

Reduction in Error Rate

This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion--a 45 percent drop. While we do not have empirical evidence supporting a specific causal relationship between the error rate decline and corrective actions, we attribute the decline to several factors:

- The Medicare Integrity Program, under HCFA's direction, provides resources to expand contractor safeguard activities, including increased medical reviews, audits, and provider education. For instance, HCFA directed its contractors to conduct extensive prepayment reviews of certain types of physician claims that we had identified as vulnerable to improper payments.

- Fraud and abuse initiatives have had a significant impact. Operation Restore Trust placed greater emphasis on more in-depth reviews of home health claims. Also, the Health Insurance Portability and Accountability Act has provided both HCFA and OIG with a stable funding source for Medicare payment safeguards and fraud and abuse activities for the next several years. Through the Health Care Fraud and Abuse Control Program, a nationwide effort was established to coordinate Federal, State, and local law enforcement activities on health care fraud. Other critical efforts include industry guidance, corporate integrity agreements with providers that settle allegations of fraud, beneficiary education, and pursuit of legislative changes.

- Virtually all major provider groups, including physicians, inpatient and outpatient services, and home health agencies, had significant error reductions since FY 1996. The provider community has been working aggressively with HCFA to ensure proper billings for services rendered, thereby ensuring compliance with Medicare program reimbursement rules.

- Finally, HCFA and OIG outreach efforts and HCFA's corrective actions were pivotal in reducing documentation errors.

Chart 1 demonstrates the reduction in improper payments by major error categories: documentation, medical necessity, coding, and noncovered services. While the drop in documentation errors is especially encouraging, errors due to the lack of medical necessity and incorrect coding remain matters of concern.

Significant Drop in Documentation Errors

Documentation errors dropped from $10.8 billion in FY 1996 to $2.1 billion in FY 1998. These errors represented the most pervasive problems in our samples for both FYs 1996 and 1997, despite Medicare regulation, 42 CFR 482.24(c), which specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments, and continued care.

We believe that documentation has improved primarily because of:

- ***HCFA and OIG outreach efforts.*** With the release of our FY 1996 report, OIG and HCFA together briefed providers on the audit results and Medicare documentation requirements. For example, HCFA hosted informational meetings with major professional organizations representing various physician specialties, the home health care industry, skilled nursing facilities, hospitals, and other providers.

- ***Implementation of HCFA's corrective action plan.*** Since our FY 1996 audit, HCFA has developed and initiated several corrective actions designed to reduce Medicare payment errors. For example, in FY 1998, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. In addition, HCFA asked contractors to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation. The HCFA dedicated approximately $14 million to increase the level of claims review in accordance with its corrective action plan. An additional $10 million was focused on medical reviews and audits of a provider group with aberrant billing practices.

For FY 1998, as seen in chart 2, the overall category of documentation includes two components: (1) insufficient documentation for medical experts to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. In FY 1997, we included an additional component to identify situations in which providers were under investigation and the OIG could not obtain medical records to support billed services. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. In contrast, working with our Office of

Investigations and the Department of Justice to satisfy legal concerns, we obtained all medical records on FY 1998 claims under investigation.

Some examples of continuing documentation problems follow:

- **Physician**. Medicare paid a physician $871 for 40 hospital visits. The medical records, however, supported only 18 visits. Therefore, payment of $479 for the 22 visits without supporting documentation was denied.

- **Home health.** A home health agency was paid $64 for skilled nursing visits. Because the medical records contained no documentation to support the provision of services, the medical reviewers denied payment.

Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries or the extent of services performed. It should be noted that HCFA subsequently upheld almost 99 percent of prior-year overpayments and recovered approximately 94 percent.

Medically Unnecessary Services

The lack of medical necessity was the highest error category this year and the second highest for both FYs 1996 and 1997. As noted in chart 3, these types of errors in inpatient prospective payment system (PPS) hospital claims have been significant in all 3 years (FY 1996 - about $3.3 billion of the total $8.5 billion; FY 1997 - about $2.3 billion of the total $7.5 billion; and FY 1998 - about $2.8 billion of the total $7 billion).

In the case of outpatient services, we noted a major shift of errors this year from the documentation category to medically unnecessary services. For example, in FY 1996, errors in outpatient claims totaled an estimated $2.8 billion, of which $2.3 billion was attributable to documentation concerns. For FY 1998, errors in outpatient claims totaled $1.7 billion, of which $1.2 billion was for medically unnecessary services.

This error category covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the claims, as illustrated in the examples below:

- **Hospital inpatient**. A beneficiary was admitted to an acute care hospital for a trachea resection surgical procedure. The beneficiary was discharged without having the procedure, and the hospital was paid $15,625. The beneficiary was subsequently readmitted to the same hospital, and the procedure was performed during the second admission. Based on a review of the medical records, the PRO concluded that the procedure should have been completed during the initial hospital stay and that the beneficiary was prematurely discharged at that

time. As a result, the second admission was determined not medically necessary and the total payment of $21,284 for that admission was denied.

- **Community mental health center**. A community mental health center was paid $21,421 for a beneficiary who received services under the partial hospitalization program. This program is designed to treat patients who exhibit severe or disabling problems related to acute psychiatric/psychological conditions. The medical reviewers determined that the beneficiary had already achieved sufficient stabilization and did not meet the definition of one who would otherwise require in-patient services. The services provided were therefore medically unnecessary, and the entire payment was denied.

- **Skilled nursing facility**. A skilled nursing facility was paid $10,428 for a 51-day skilled nursing stay. However, the patient's medical records documented that the patient received only maintenance-level (nonskilled) nursing home care, such as routine occupational therapy and the continuation of routine medication. Because Medicare does not reimburse for nonskilled services, the entire payment was denied.

Incorrect Coding

Incorrect coding is the second highest error category this year, representing $2.3 billion, or almost 18 percent, of the total improper payments. As illustrated in chart 4, physician and inpatient PPS claims accounted for over 80 percent of the coding errors in FYs 1996, 1997, and 1998.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical review staff determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which we offset against identified upcoding situations.

Some examples of incorrect coding follow:

- **Hospital.** A hospital was paid $33,380 for performing a partial thyroidectomy to remove part of the patient's thyroid gland. Based on the medical records, the surgical procedure actually performed was a less complex partial parathyroidectomy to remove small glands and tissues located near the thyroid gland. The PRO's correction of the procedure code produced a lesser valued diagnosis-related group (DRG) of $19,695, resulting in denial of $13,685 of the payment.

- **Physician.** A physician was paid $103 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the medical review staff determined that the provider's documentation supported a less complex, expanded problem-focused history, expanded problem-focused examination, and straightforward medical decisionmaking. As a result, $46 of the payment was denied.

- **Physician.** A physician was paid $108 for a hospital visit which included a detailed interval history, a detailed examination, and medical decisionmaking of high complexity. The medical

review staff determined that the level of service actually provided supported a lower level procedure code of focused interval history and decisionmaking of moderate complexity. Because the provider should have billed a lower level of care, $30 of the payment was denied.

Noncovered/Unallowable Services

Errors due to noncovered or unallowable services have consistently constituted the smallest error category. For the last 2 years, the majority of errors in this category were attributable to physician and outpatient claims.

Unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. For example:

- **Outpatient.** An outpatient provider was paid $56 for laboratory work which, according to the medical records, was part of a routine physical examination. Since Medicare does not cover such examinations, the payment was denied.

- **Physician.** A physician was paid a total of $34 for two claims for treating a beneficiary. Medical review follow-up determined that the treatment involved bioelectric medicine. Since this procedure is considered experimental and is not covered by Medicare, the total payment was denied.

Conclusions and Recommendations

We are most encouraged that actions on the part of the Administration, the Congress, and the provider community have contributed to a reduction in payment errors--and particularly that providers are doing a better job in documenting services to Medicare beneficiaries. But we caution that diligence is needed to sustain the apparent downward trend. In short, our audit results for the 3-year period clearly demonstrate that the Medicare program remains inherently vulnerable to improper and unnecessary benefit payments. We still have an unacceptable $12.6 billion estimated loss from the Government's coffer, and the FY 1998 improper payments relating to medically unnecessary services ($7 billion) and improperly coded services ($2.3 billion) are of significant concern.

Additionally, a number of issues could negatively affect future error rates:

- ***Substantial Year 2000 initiatives.*** More than 100 claim processing systems are being renovated/changed to comply with millennium requirements.

- ***Instability of Medicare contractors***. The HCFA has experienced a record number of contractor terminations and consolidations.

- ***Legislative requirements.*** Additional requirements resulting from the Balanced Budget Act of 1997 must be implemented and enforced.

To ensure progress in reducing past problems while keeping abreast of continuing changes in the health care area and adequately safeguarding the Medicare Trust Fund, we recommended, among other things, that HCFA:

- enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare payments and

- continue to direct that the Medicare contractors and PROs expand provider training to (1) further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare, and (2) identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews.

We believe these types of reviews are critical to reducing improper Medicare payments and ensuring continued provider integrity.

The HCFA generally concurred with these recommendations. We expect that HCFA's testimony today will address the specific corrective actions being taken.

FINANCIAL STATEMENT AUDIT

We are pleased to report that HCFA has continued to successfully resolve many previously identified financial accounting problems. For example, substantial progress was made in improving Medicare and Medicaid accounts payable estimates, as well as estimates of potential improper payments included in cost reports of institutional providers. However, our opinion on the FY 1998 financial statements remains qualified. In accounting terms, a qualification indicates that we still found insufficient documentation to conclude on the fair presentation of all amounts reported.

Medicare Accounts Receivable

Most significantly, Medicare accounts receivable (i.e., what providers owe to HCFA) were not adequately supported. The OIG previously reported that Medicare contractors did not have adequate internal controls over these receivables. Specifically, they used various ad hoc spreadsheets and periodic financial reports in lieu of entry and tracking in a more formal accounting structure, such as dual-entry recordkeeping and having subsidiary accounting records for each provider. The contractors reported over $22.9 billion of Medicare accounts receivable activity during FY 1998, resulting in a reported gross accounts receivable of approximately $5.8 billion and net accounts receivable of $3.3 billion, which represents approximately 90 percent of the $3.6 billion of total Medicare accounts receivable at yearend.

We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors in our sample. Some contractors were unable to support the beginning balances, others reported incorrect activity, including collections, and finally others were unable to reconcile their reported ending balances to subsidiary records. We also found that substantial amounts of receivables had been settled with insurance companies but were still presented as outstanding accounts

receivable. As a result of these problems, we could not determine whether the Medicare contractors' accounts receivable balances and activities were fairly presented.

Material Weaknesses

Material weaknesses are serious deficiencies in internal controls that could lead to material misstatements of amounts reported in the financial statements in subsequent years unless corrective actions are taken.

The FY 1998 report on internal controls notes three material weaknesses:

1. As discussed above, significant improvements are needed in Medicare contractors' development, collection, and reporting of accounts receivable.

2. Financial reporting remains a material weakness because Medicare contractors have not adequately reconciled expenditures reported to HCFA. Also, the process for preparing financial statements is manually intensive.

3. The HCFA central office and Medicare contractors continue to have material weaknesses in electronic data processing controls relating to security access and application development and change controls.

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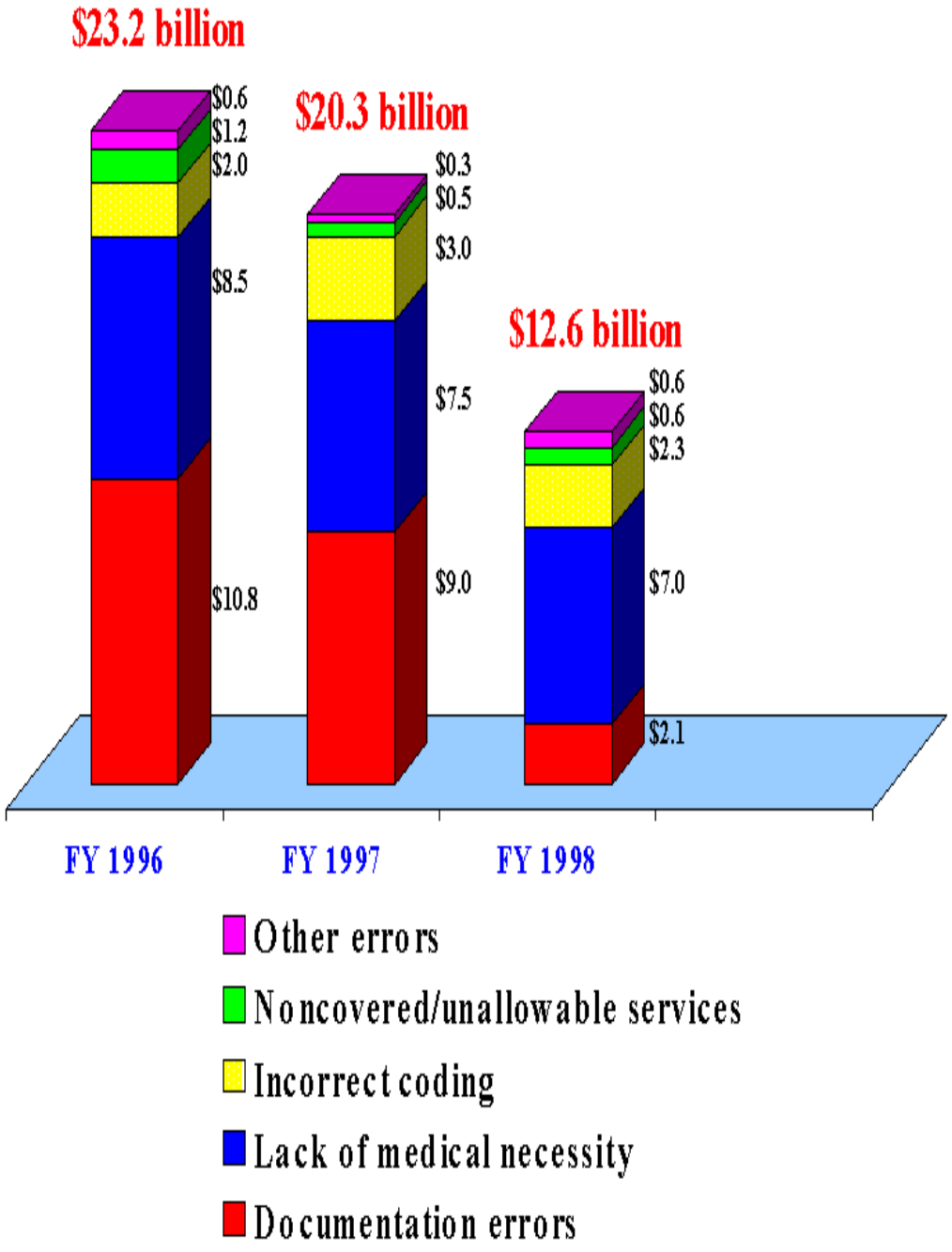
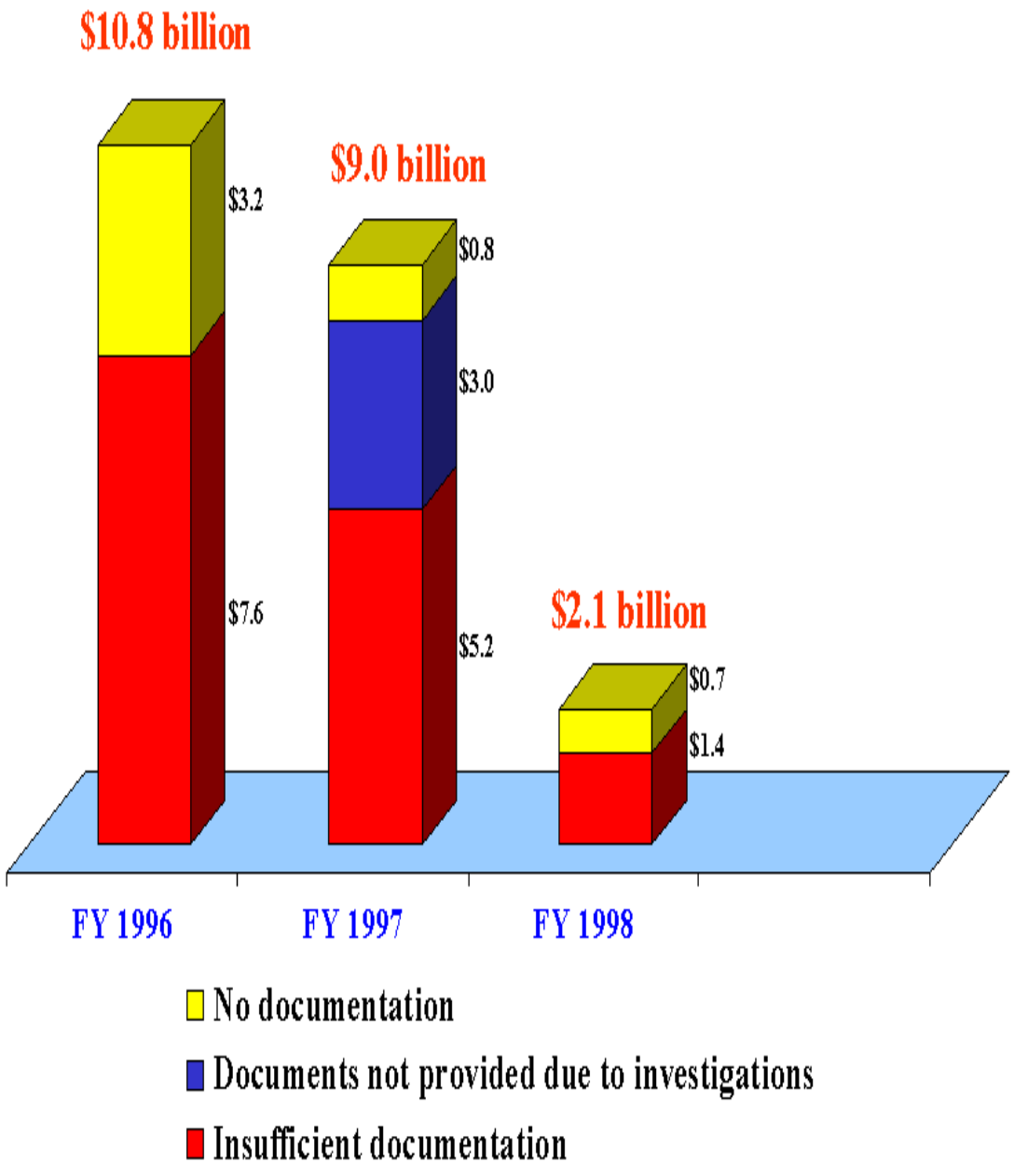
I appreciate the opportunity to appear before you today and to share our reports with you, and I will be happy to answer any questions you may have.

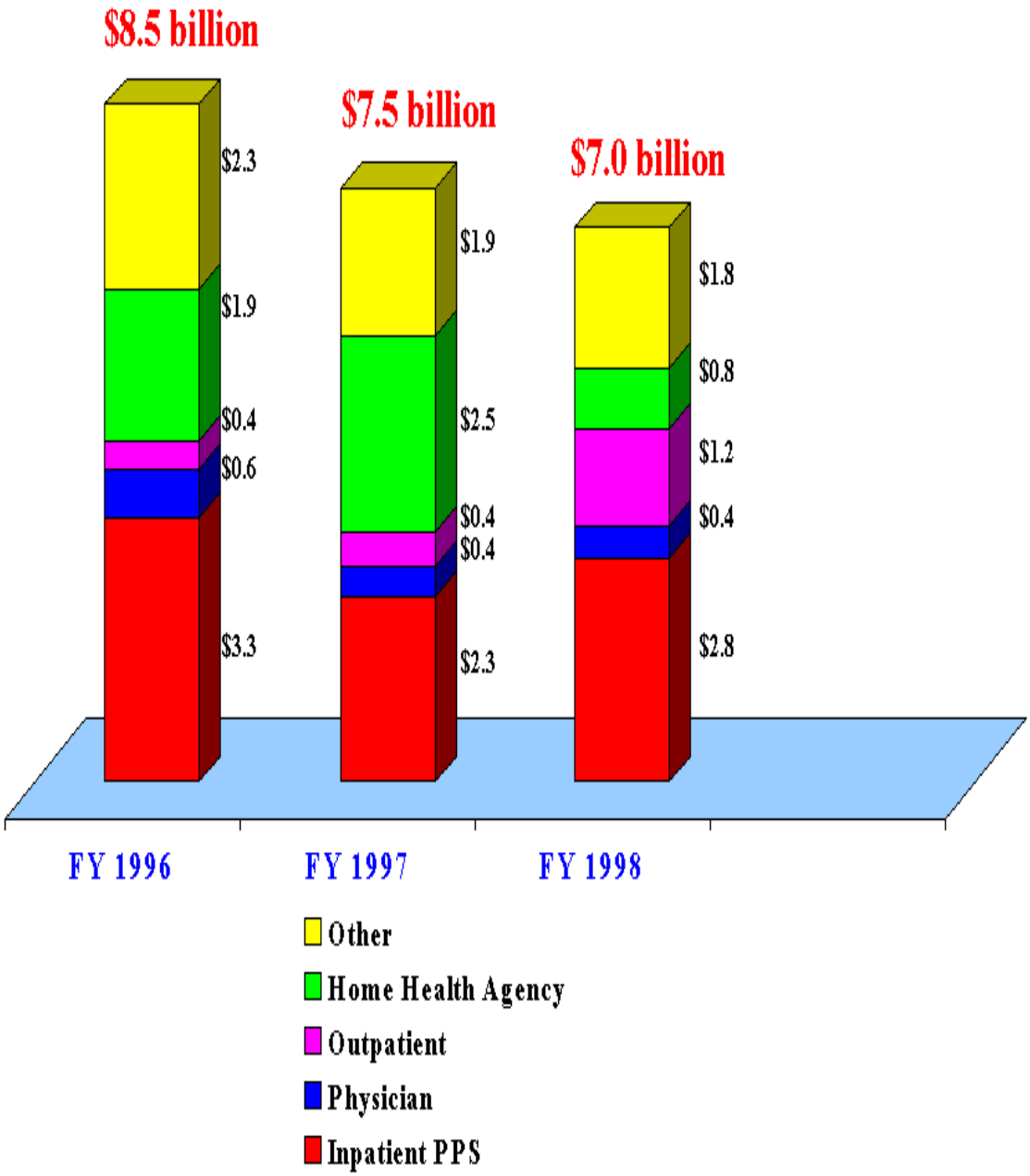
Estimated Improper Payments by Type of Error (Dollars in Billions)



Documentation by Error Category (Dollars in Billions)



Errors Due to Lack of Medical Necessity by Provider Types (Dollars in Billions)



Errors Due to Incorrect Coding by Provider Types (Dollars in Billions)